# Child Health Screening Form

Date: _____ Child Care Program: _____

Please answer the following questions to the best of your ability:

| Child's Name | Does your child have any symptoms of COVID-19 listed below? Y or N | Has your child or anyone in the household traveled outside of ME, NH, NY, CT, NJ, VT, or MA in the past month? Y or N | Has your child come into contact with anyone who has tested positive with COVID-19? Y or N | Is anyone in your child's household experiencing signs of illness? Y or N | Child's temperature | Parent signature (agreeing to the information) | Staff person initials |
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**Symptoms of COVID-19: Fever (body temperature above 100.4° Fahrenheit) or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose (in conjunction with other symptoms), Nausea or vomiting, or Diarrhea**